

## County of Dukes County

### Pre-employment/Post-Offer Medical/Job History

We are an equal opportunity employer. The Civil Rights Act of 1964 prohibits discrimination in employment because of race, color, religion, sex or national origin. The Age Discrimination in Employment Act prohibits discrimination on the basis of age with respect to individuals who are at least 40 years old. The Americans with Disabilities Act of 1990 prohibits discrimination in employment because an individual is handicapped if the individual's handicap can be accommodated within certain guidelines, and the individual can perform the job duties with or without such accommodation. State laws may also prohibit the above types of discrimination.

#### PERSONAL INFORMATION: (Please Print)

NAME: \_\_\_\_\_ Date: \_\_\_\_\_  
FIRST MIDDLE LAST

ADDRESS: \_\_\_\_\_  
NUMBER STREET CITY STATE ZIP CODE

PHONE NO. ( ) \_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_  
AREA CODE

POSITION OFFERED: \_\_\_\_\_

**PLEASE CIRCLE THE CORRECT ANSWER TO THE QUESTIONS BELOW.  
 IF YOU ANSWER YES TO ANY QUESTIONS, PLEASE EXPLAIN AND GIVE DETAILS.**

#### OCCUPATIONAL HISTORY:

1. Have you ever had an injury, illness or disease caused by your work? YES NO  
 If yes, describe injury, illness or disease, cause, duration, etc. \_\_\_\_\_

2. Have you ever applied for Workers Compensation Benefits? YES NO  
 If yes, describe reason, duration, received benefit, etc. \_\_\_\_\_

3. Have you ever been eligible for Workers Compensation? YES NO  
 If yes, explain. \_\_\_\_\_

4. Were you ever rejected from employment for health reasons? YES NO  
 If yes, explain. \_\_\_\_\_

5. Are you now involved in, or has your work ever involved:

	YES	NO	YEARS		YES	NO	YEARS
*Paint Manufacturing	[ ]	[ ]	_____	*Continuous Motion or Carpal Tunnel Injury	[ ]	[ ]	_____
*Wood Dust Exposure	[ ]	[ ]	_____	*High Noise Area	[ ]	[ ]	_____

6. Do you suffer from dust disease or Emphysema?

YES NO

If yes, explain. \_\_\_\_\_

7. Have you ever had any injury or illness on the job that resulted in hospitalization, surgery, or lost time from work? YES NO

If yes, explain. \_\_\_\_\_

8. Have you ever suffered a permanent disability as a result of an on-the-job injury or illness?

YES NO

If yes, explain. \_\_\_\_\_

9. Have you suffered the loss of a:

	YES	NO		YES	NO		YES	NO
Hand?	[ ]	[ ]	Foot?	[ ]	[ ]	Eye?	[ ]	[ ]
Arm?	[ ]	[ ]	Leg?	[ ]	[ ]	Hearing Loss?	[ ]	[ ]

10. Do you have any condition which may limit your work or require a special work assignment for a temporary or permanent period?

YES NO

If yes, explain. \_\_\_\_\_

11. Have you ever been sensitive to any materials or the environment of your work?

YES NO

If yes, explain. \_\_\_\_\_

12. Have you ever had a skin rash or any other condition from any materials or environment of your work?

YES NO

If yes, explain. \_\_\_\_\_

13. Have you ever worked in a job that was noisy, made your ears ring or made it hard for you to hear?

YES NO

If yes, explain. \_\_\_\_\_

14. Have you ever been told that you have a hearing loss?

YES NO

If yes, explain. \_\_\_\_\_

15. Have you ever suffered, or do you currently suffer, from a back injury? YES NO  
 If yes, explain. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

16. Have you ever suffered, or do you currently have a hernia? YES NO  
 If yes, explain. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

17. Have you ever suffered, or do you currently suffer from an eye injury or temporary blindness or any other visual difficulty not corrected by glasses? YES NO  
 If yes, explain. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

18. How many days have you missed from work in the last twelve (12) months due to injury or illness? YES NO  
 If yes, explain. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

19. Have you ever lost a job because of use of alcohol or drugs? YES NO  
 If yes, explain. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

20. In order that first aid and safety personnel may be informed, when appropriate, please state if you have ever suffered from, or are currently suffering from a condition which might require emergency treatment or special handling should an emergency arise, such as:

	YES	NO		YES	NO
Allergies	[ ]	[ ]	Heart Disease	[ ]	[ ]
Asthma	[ ]	[ ]	Hemophilia	[ ]	[ ]
Chest Pain	[ ]	[ ]	Hepatitis	[ ]	[ ]
Convulsion	[ ]	[ ]	High Blood Pressure	[ ]	[ ]
Diabetes	[ ]	[ ]	Low Blood Pressure	[ ]	[ ]
Enlarged Heart	[ ]	[ ]	Low Blood Sugar	[ ]	[ ]
Epilepsy	[ ]	[ ]	Seizure	[ ]	[ ]
Heart Attack	[ ]	[ ]			

Other conditions not listed above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

For each yes, please explain:

Condition	Dates	Explanation




21. Do you regularly take medication or prescription drugs?

YES

NO

If yes, state:

Medication	Doctor Prescribing	Dosage	Reason	Side effects

22. Have you ever had surgery?

YES

NO

If yes, state:

Type of Surgery	Doctor	If Hospitalized	Date of Surgery	Date of Recovery	Restrictions

The facts set forth above are true and complete. I hereby authorize investigation of all statements contained in this questionnaire and full disclosure regarding my responses. I hereby release any such person or organization providing information regarding my responses from any and all liability which may result in furnishing such information or opinion. I hereby release **Dukes County** and any person, organization or prior employer from any obligation to provide me with written notification of such disclosure. I understand that false statements in this questionnaire, as well as misrepresentations or omissions of information, shall be considered cause for dismissal. I understand and agree that if in the opinion of the **Dukes County**, the results of the investigation are unsatisfactory, that my offer of employment may be withdrawn or my employment with the **Dukes County** may be terminated.

I certify that I am genuinely interested in working in the position I have been offered and am accepting this position for no other purpose.

I further understand that the **Dukes County** may require a medical examination by a designated physician (1) after I have received an offer of employment and prior to my commencement of employment duties; and (2) during the course of my employment as required by business necessity and for job related purposes. I hereby consent to such examinations and recognize that employment is contingent upon receipt of a satisfactory medical evaluation. I further understand and agree that prior to commencing employment or after I am employed, I may be requested to submit to tests to determine the presence of alcohol or illegal drugs, and agree to the release of any such test results to appropriate **Dukes County** personnel, and agree that if I refuse and/or fail such tests before commencing employment, my offer of employment will be revoked, or if I refuse and/or fail such tests after being employed, my employment will be terminated.

I agree to refrain from smoking in the building and all other designated no-smoking areas.

I have read, understand, and agree to the above statements and conditions of employment.

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATED: \_\_\_\_\_

DOC:Pre-EmploymentForm